Ocean County Health Department
P.O. Box 2191
Toms River, New Jersey 08754-2191

Pneumococcal Vaccination Consent Form

Please Print: Date of Birth: ____/____/____ Gender: ___Female ___Male

Name: First | **Last**

Address: ____

City: ___________________________ State: ______ Zip: ___________ Phone Number: ___________________

1. Have you ever had the pneumococcal vaccine before? __Yes __No
2. Have you ever had a severe allergic reaction to the pneumococcal vaccine? __Yes __No
3. Does the person receiving the vaccine have a fever of ≥100 degrees F? __Yes __No
4. Are you 65 years of age or older? __Yes __No

I have read, or have had explained to me, the CDC Vaccine Information Statement about pneumococcal polysaccharide vaccine. I acknowledge that I have been given the opportunity to review the OCHD Notice of Privacy Practices on this date. I understand that this vaccine may cause injection site discomfort in some people but will not cause pneumonia. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the pneumococcal polysaccharide vaccine and request that the vaccine be given to me or the person named above for whom I am authorized to make this request. I have answered all questions truthfully and accurately. I request that payment of authorized Medicare benefits be made to me or on my behalf to the Ocean County Health Department for any services furnished to me by the OCHD. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: ____ Date: _________________

Medicare Number * Exactly as it appears on Medicare Card

____

Date of Vaccination: __ __ / __ __ / __ __

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY

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☐ Pneumococcal Polysaccharide Vaccine

Site:	Vaccine Lot #/Exp
R / L Deltoid- IM	

8/2020